



## TOOLBOX

# Taking a sexual history

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Many doctors feel uncomfortable about their ability to take an appropriate history from a patient with a sexual problem. In part, the discomfort lies in the doctor's feelings of embarrassment and the patients ambivalence about bring up the topic. Patients may feel ashamed or even humiliated at having to ask for help with a sexual problem that they consider private and that they should be able to cope with themselves. This is particularly so with men, especially young men, who have to admit to erectile dysfunction and therefore, as they see it, the loss of their masculinity. Some physicians have found that they can avoid this initial difficulty by giving patients a waiting room preconsultation written questionnaire. Many patients like this but some dislike its anonymity and apparent coldness.

As with other history taking, the doctor must carefully choose words, avoid closed-ended questions, be nonjudgmental, avoid labels with hidden meaning and carefully observe body language.

### Interview technique

Above all, there must be sufficient time allowed, and 45-60 minutes is an ideal that is unfortunately not often possible to achieve, especially as managed care invades our health care system. A patient's ability to bring up a sexual problem may be tentative and hidden by euphemisms, with statements like "I think I need a check up" or "by the way, I have a [discharge, itch, soreness] down below." These comments may well be slipped into a visit about some other medical. Various interview techniques can be used to help patients feel more comfortable during the interview. These include the manner of greeting a patient, seeing that the patient is seated comfortably, and ensuring privacy (especially in a clinic setting). Very early in the discussion, the patient must be assured of confidentiality, particularly with regard to clinic and hospital staff. If the seat

is placed at the side of the desk, there is more opportunity to observe the patient's body language, as well as this being a more friendly arrangement.

Patients' body language, such as defensively crossing arms, can sometimes give hints as to their state of mind.

We find that useful observations on patients' body language include:

- Their use of their hands and arms such as uneasily fiddling with a ring, defensively crossing arms, or protectively holding a bag or briefcase on a lap.
- Pectoral flush, which creeps over the upper chest and neck (in some younger men as well as women) and suggests unease despite an outward appearance of calm.
- The body's position in the chair is a depressed slump, or tautly sitting upright, or the relaxed sprawl.
- Postural echo, when doctor and patient sit in mirror images of each other's position adopted when there is harmony and empathy between the doctor and patient.

When people talk about embarrassing subjects, they are often vague and in direct. The clinician should try to clarify their meaning. Words such as "impotence," for example, can mean different things to different men (and their partners), including failure to get an erection, failure to maintain an erection, and premature ejaculation. Similarly, a phrase such as "I'm sore down below" can mean anything from pruritus ani to some anatomical problem such as a prolapse or genital warts. Careful and tactful elucidation is needed, and vagueness must be clarified. The questioner has to be particularly sharp in picking up what the patient is trying to say and be relaxed and unfazed by the subject matter. Physicians need to be careful not to overstate their concern.

Factors to be noted during the interview include:

- The patient's sexual preference for men, women or both
- Cohabital status (married, living with partner, etc.)
- Approximation of previous life time sexual partners; approximation of partners in past six months
- How long has patient been with the current partner?
- Does the patient have children? Who do they live with?
- Is there stress between the patient and their sexual partner or in the family?
- What types of sexual behaviors does the patient engage in? How often? Are these activities mutual enjoyable?
- If the patient is a female, it is important to ask about menstrual history and regularity of cycles
- Use of birth control
- History of sexually transmitted diseases
- For both men and women it is important to ask about a history of being sexually abused (including rape, child abuse, domestic violence)
- Use of prescribed medications or recreational drugs

### Choice of terminology

One difficulty that bothers many doctors is whether to use vernacular terms in discussions because of their emotional charge, or whether to use only medical terms. We believe it best to avoid a hard and fast rule but to tailor the terminology to the patient. Patients too, because of embarrassment about using colloquialisms and fear of causing offense, may try to express their problem

with inaccurate medical terminology. Both can cause problems in getting an accurate history. Some younger patients, especially women patients, may not know the meaning of "orgasm" but will understand "come." While fellatio and cunnilingus are not words in general use, the use of their street equivalent would allow for a more relaxed and empathic discussion. Certainly, "oral sex" is more acceptable to men and women of all ages. Usually, the line is very fine and is often related to age and gender.

A 16-year-old was struggling to find medical words to explain his anxieties about masturbation and ejaculation. When the doctor tried to help him out by using colloquial terms the boy looked startled and then grinned and said, "I didn't know doctors knew those words." The rest of the consultation was much more relaxed and informative.

### Communication

The way open and closed questions are used in proper history taking are crucial, but take on an even greater importance when taking a sexual history. A closed question demands a specific reply, such as "Yes" or "No". Characteristic closed ended questions include: "Have you had this problem before? Does it hurt when you pass water? Did you practice safe sex?"

Starting with an open question "How can I help you?" and continuing with open ended questions such as "what do you think caused the difficulty?" gives patients more opportunity to expand on their concerns. Many younger doctors are worried that a garrulous person might get out of hand, but remaining in control is a skill a good interviewer learns quickly. Judgmental questions, "You didn't have sex with a prostitute did you?" "You don't allow him to have anal intercourse do you?" should be avoided like a sexually transmitted disease.

Silence is a powerful tool in taking a good history. Many doctors find it extremely difficult to endure a moment of silence. In fact, most doctors can not endure more than 5 seconds of not talking themselves. Silence can be an extremely useful tool if used properly. The patient often uses this time to order his or her thoughts. Valuable details may be lost if those thoughts are cut

interrupted by an inappropriate statement from the doctor. A rule of thumb is to wait for an answer; it will come.

Another useful tool is to use the "echo" or verbal repetition to elicit information. Repetition of the last word or phrase, especially if it is one which is full of emotionally loaded, is a powerful technique and can elicit much information, although it may seem artificial at first.

As an example:

*"Doctor, I think I need a check up"*

*"Yes, of course. It's been a while since the last one. Let me start with your blood pressure...."*

Compare this with

*"Doctor, I think I need a check up"*

*"Check up?"*

*"Yes, I'm not performing as well as I used to"*

*"Performing?"*

*"Yes, well, you know, I think I'm impotent. My wife is very good about it and doesn't complain, but I feel so guilty and ashamed"*

*"Ashamed?"*

*"I feel terrible. I don't feel a man any more, especially as we used to have such a good sex life...."*

Although a joint interview is always much more valuable, patients often prefer to discuss things alone in the first instance. A warm invitation for the partner, coupled with the observation that a sexual problem is not the patient's problem alone, can put the patient's anxieties into perspective.

To be complete, the history (see box) must include several factors.

### Social history

A detailed social history helps put the patient's sexual difficulties into context. Taking a social and medical history before exploring the problem allows the patient time to relax while talking about familiar things such as home, children and work and enables the doctor to put the problems into perspective. Even if the doctor knows the patient well, a review of the social history will update the patient's chart and new information may be uncovered that could be relevant to the current sexual problem.

### Questions to be asked in sexual history

- What is the problem as the patient sees it?
- How long has the problem been present?
- Is the problem related to the time, place, or partner?
- Is there a loss of sex drive or dislike of sexual contact?
- Are there problems in the relationship?
- What are the stress factors as seen by the patient and by the partner?
- Is there other anxiety, guilt, or anger not expressed?
- Are there physical problems such as pain felt by either partner?

### Medical history

It used to be thought that all sexual problems, especially erectile dysfunction, were psychogenic in origin. General opinion has shifted to accepting that a large proportion have a physical basis, though, not surprisingly, often with a psychogenic overlay. It is therefore important to take a detailed medical history, particularly bearing in mind those illnesses that may affect sexual performance. Diabetes can eventually cause impotence in up to half of affected men. Depression and psychotic illnesses cause diminished sexual desire (but not necessarily loss of function) in a high proportion of both men and women, but careful questioning is needed to elicit them. Altered sleep pattern is a valuable indicator of depression. Heart disease, especially when combined with hyperlipidemia and arteriopathy, accounts for erectile dysfunction in many men. Other hormone deficiencies, especially thyroid and testosterone, reduce sexual desire and performance in both sexes. Operations and trauma, especially gynecological and urological, can cause sexual problems. Damage to the pelvis or spine is another obvious cause. Prolactinoma may, rarely, present with a loss of sexual desire and headaches in a younger man. Pain of arthritis, vaginal atrophy in the older woman or a phimosis may be off putting to one or other partner.

### Medical and recreational drugs

Many drugs, especially hypotensives agents, alcohol, nicotine and many over the counter medications, that contain anticholinergics properties, can have a profound effect on sexual performance.

## Best Practice

**Table 1** Commonly prescribed drugs associated with sexual dysfunction (list not fully comprehensive)

Drug	Erectile dysfunction	Altered drive	Ejaculatory disorder	Orgasmic disorder	Priapism
<b>Anticonvulsants</b>					
Carbamazepine	X				
Phenytoin	X	X			
Primidone	X	X			
<b>Antidepressants</b>					
<i>Tricyclics</i>					
Amitriptyline	X	X	X		
Amoxapine	X	X	X		
Clomipramine	X	X	X	X	
Imipramine	X	X	X	X	
Maprotiline	X	X			
Nortriptyline	X	X			
Protriptyline	X	X	X		
<b>Monoamine oxidase inhibitors</b>					
Phenelzine	X	X	X	X	
<b>Selective serotonin reuptake inhibitors</b>					
Fluoxetine	X		X		
Fluvoxamine	X		X		
Paroxetine	X		X		
Sertraline	X		X		
<b>Antipsychotics</b>					
Chlorpromazine	X	X	X		X
Fluphenazine	X	X	X		
Haloperidol	X		X		
Thioridazine	X		X	X	X
Benzodiazepines	X	X	X	X	
<b>Antihypertensives</b>					
Atenolol	X				
Clonidine	X		X	X	
Guanethidine	X	X	X		
Hydralazine	X				X
Labetalol	X	X	X		X
Methyldopa	X	X	X	X	
Metoprolol	X	X			
Pindolol	X				
Prazosin	X				
Propranolol	X	X	X	X	
Reserpine	X	X	X		
Timolol	X	X			
Verapamil	X				
<b>Diuretics</b>					
Amiloride	X	X			
Chlorthalidone	X	X			
Indapamide	X	X			
Spironolactone	X	X			
Thiazides	X				
<b>Antiemetics</b>					
Metoclopramide	X	X			
<b>Non-steroidal anti-inflammatory drugs</b>					
Naproxen	X		X		
<b>Anticholinergics</b>					
Atropine	X				
Diphenhydramine	X	X			
Hydroxyzine	X	X			
Propantheline	X				
Scopolamine	X				
<b>Antispasmodics</b>					
Baclofen	X		X		
<b>Hypnotics</b>					
Barbiturates	X	X	X		

Inadequate hormone replacement therapy in menopausal women can cause vaginal atrophy and dryness leading to pain during sexual intercourse. This may not be volunteered by, or even be apparent to, her partner and is a good reason to try to listen to the couple together.

Cannabis can cause an initial euphoria, improving sexual confidence, but, like alcohol, it can greatly diminish performance. Other drugs, including the so called hard drugs, have a deleterious long term effect on sexual performance. Commonly prescribed drugs associated with sexual dysfunction are listed in Table 1.

### Talking with the couple

Marital dysfunction or just plain sexual boredom after many years of being together can be a major cause of erectile dysfunction. In men with erectile dysfunction it is helpful to know the patient's, and especially his partner's, views of the causes. This often reveals their anxieties about other problems, as well. It is also useful to know the speed of onset: organic causes such as diabetes tend to develop slowly whereas psychogenic ones tend to appear more rapidly.

A psychogenic cause of erectile dysfunction is considered when the patient becomes erect during the night or upon early morning waking or if he can masturbate successfully, although many are reluctant to admit this in front of their partner. (Erectile dysfunction is covered in a later article in Tool-box)

### Strains on the relationship

Strict upbringing and religious beliefs, especially if there is disparity between the partners (as in mixed marriages), can often have a devastating effect on a sexual relationship. Other issues to consider that add strain on sexual relations include unemployment (or the threat of it), retirement (through loss of self esteem) and menopause. Has the menopause or a hysterectomy changed the way a woman perceives herself? Does she feel less feminine or attractive to her partner? These aspects may need very tactful questioning to elicit, and require sensitivity on the part of the doctor.